Decision-making capacity: from testing to evaluation

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Abstract: Decision-making capacity (DMC) is the gatekeeping element for a patient's right to self-determination with regard to medical decisions. A DMC evaluation is not only conducted on descriptive grounds but is an inherently normative task including ethical reasoning. Therefore, it is dependent to a considerable extent on the values held by the clinicians involved in the DMC evaluation. Dealing with the question of how to reasonably support clinicians in arriving at a DMC judgment, a new tool is presented that fundamentally differs from existing ones: the U-Doc. By putting greater emphasis on the judgmental process rather than on the measurement of mental abilities, the clinician as a decision-maker is brought into focus, rendering the tool more of an evaluation guide than a test instrument. In a qualitative study, the perceived benefits of and difficulties with the tool have been explored. The findings show on the one hand that the evaluation aid provides basic orientation, supports a holistic perspective on the patient, sensitizes for ethical considerations and personal biases, and helps to think through the decision, to argue, and to justify one's judgment. On the other hand, the room for interpretation due to absent operationalisations, related ambiguities, and the confrontation with one's own subjectivity may be experienced as unsettling.

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ABSTRACT

Decision-making capacity (DMC) is the gatekeeping element for a patient's right to self-determination with regard to medical decisions. A DMC evaluation is not only conducted on descriptive grounds but is an inherently normative task including ethical reasoning. Therefore, it is dependent to a considerable extent on the values held by the clinicians involved in the DMC evaluation. Dealing with the question of how to reasonably support clinicians in arriving at a DMC judgment, a new tool is presented that fundamentally differs from existing ones: the U-Doc. By putting greater emphasis on the judgmental process rather than on the measurement of mental abilities, the clinician as a decision-maker is brought into focus, rendering the tool more of an evaluation guide than a test instrument. In a qualitative study the perceived benefits of and difficulties with the tool have been explored. The findings show on the one hand that the evaluation aid provides basic orientation, supports a holistic perspective on the patient, sensitizes for ethical considerations and personal biases, and helps to think through the decision, to argue, and to justify one's judgment. On the other hand, the room for interpretation due to absent operationalisations, related ambiguities and the confrontation with one's own subjectivity may be experienced as unsettling.

Keywords: competence, decision-making capacity, tool, documentation, evaluation, ethics

INTRODUCTION

Decision-making capacity or competence (DMC) is the gatekeeper for a patient's right to self-determination defining whether the patient him- or herself or a surrogate has decisional authority regarding the medical decision at hand (Faden and Beauchamp, 1986).[1] In general, DMC has to be assumed in adults and there is a related moral imperative to only call a patient's DMC into question if there are substantial doubts (e.g., Grisso and Appelbaum 1998b; Nicholson et al. 2008; den Hartogh, 2016). Such doubts can arise for example in the context of patients with dementia, patients with mental disabilities or mental disorders such as severe depression or severe schizophrenia. However, it is important to note that doubts about DMC can arise in any patient and that a lack of DMC is not restricted to particular diagnostic groups or medical specialties (e.g., Grisso and Appelbaum, 1995a, 1995b; Sessums et al. 2011; Swiss Academy of Medical Sciences, SAMS; 2019). Due to the profound legal and ethical implications, a thorough and appropriate evaluation of a patient's DMC is required.

Clinical practice and empirical research have shown that DMC evaluations pose great challenges, and that clinicians often feel unsure or unable to adequately cope with the task (Hermann et al. 2014). Moreover, concerns have been raised that DMC judgments are often far too subjective or arbitrary resulting in poor interrater reliability (Marson et al. 1997; Sturman 2005).

To overcome these problems instruments have been developed to support DMC assessments (Lamont et al. 2013). These tools usually come in the form of structured or semi-structured interview guides for testing relevant mental abilities. They provide operationalisations of criteria and scoring instructions to rate the degree of impairment (e.g., Grisso and Appelbaum 1998a). This way, interrater variation and subjective biases can be reduced (Sturman 2005).

[1] When patients are judged to be incompetent their will is still relevant. However, decision making will be guided by their will as previously expressed in advance directives or as presumed by surrogates. The patient may be consulted about the decision that needs to be taken but will at this point not have the authority (and responsibility) to make the decision him- or herself.

However, only one particular sort of variation is prevented: existing tools are able to ensure that different assessors interpret criteria in the same way and assign similar scores with regard to one and the same impairment. Thus, they are able to tackle biases that occur in the course of describing and appraising the degree of impairment of specific mental abilities.

Yet it is of great importance to realise that the assessment of mental abilities is not tantamount to a DMC judgment (see e.g., Etchells et al., 1999). This becomes particularly evident in so-called «grey area» cases, where mental abilities are not so clearly deficient that decision-making incapacity becomes obvious. After the patient has been assessed, descriptive data must be integrated and translated into a dichotomous judgment of *competent* or *incompetent* (Grisso and Appelbaum 1998b). This involves an additional, normative component reflecting the widely accepted understanding that DMC goes beyond mere description and necessarily involves a value judgment (Berghmans et al. 2014; Grisso and Appelbaum 1996). Thus, interrater variation and subjective biases that arise in the course of this translation are not accounted for in existing tools. Neither do these tools provide guidance for arriving at a final judgment. On the contrary, there is a danger that such tools purport more objectivity than there really is (Charland 2001).

There are several reasons why the evaluation of decision-making capacity is an important ethical and not just a technical issue. The mere fact of being judged as incompetent to make decisions bears high significance for many people, and the consequences, e.g. of being denied to leave the hospital at one's will can be considerable. The question of how such evaluations can be done responsibly is of high moral relevance.

Also, every DMC evaluation is an inherently normative task that includes ethical reasoning. Values comprise a conception of the "good" which in turn influences DMC evaluation. In a survey among 637 physicians in Switzerland by Hermann and colleagues (2015) including case

vignettes on chemotherapy and assisted suicide, a quarter of all physicians indicated that their own set of values rather or very much influences their DMC evaluations.

The impact of values can take different shapes. Personal values can influence how impairments of mental abilities are weighted in the DMC evaluation, for example, how much significance is given to emotional criteria in comparison to cognitive criteria. Moreover, it is likely that physicians' personal inclination in balancing the moral principles of respect for self-determination and beneficence impacts a competence or incompetence judgment since exactly these values are at stake in DMC evaluations. Various other values may also impact the evaluation. The important question is whether these impacts are adequate or rather indicate an undue personal bias.

In the aforementioned study, it has been shown that about 16% of "physicians said that they must be personally convinced that assisted suicide is the best option available to the patient as a criterion for deeming the patient competent. Certainly, physicians are allowed to have different attitudes towards assisted suicide, and to refuse assistance. However, it seems unduly paternalistic to deem the patient incompetent because of one's personal conviction that assisted suicide is not a good option" (p. 743). Other examples of undue influences are if a patient is considered incompetent when the clinician is strongly influenced by her annoyance at a patient's refusal to try another – in her eyes promising – therapy, or by her shock and dismay at a young woman to curb her daily calorie intake, although she is already underweight. From an ethical point of view, it is highly problematic when personal convictions of the evaluating clinicians contaminate DMC evaluations and introduce unjustified medical paternalism through the back door. Consequently, safeguards should exist in order to prevent personal convictions of the evaluating clinicians from skewing the DMC evaluation process. Doctors who have deep moral objections to certain patient decisions "should invoke conscientious objection and

remove themselves from the process rather than trying to impose their views on their patients" (Shaw et al. 2018, p. 394).

Moreover, in search for objectivity, there is another shortcoming of existing assessment tools: only those criteria are considered that are relatively easily operationalized such as cognitive abilities. This is insofar a shortcoming as emotions and values have been repeatedly shown to be relevant for DMC (Hermann et al. 2016). Existing assessment tools neglect these factors, probably due to measurement limitations. Emotional and motivational factors are difficult to operationalize because they require more context sensitive evaluations (Hermann et al. 2016). In addition, their evaluation is less value free as the appraisal of cognitive factors. We believe that the exclusion of emotional and valuational aspects in standardized assessment tools (in order to uphold objectivity) does not prevent related considerations to influence DMC judgments, especially if we consider the leeway in the aforementioned translation process.

Thus, existing assessment tools ignore essential aspects in the evaluation process that deal with normativity, and with it, the evaluator's own subjectivity. In view of this shortcoming, we see great need and potential for a new generation of tools that pursue a more modest yet more realistic strategy by appreciating normative considerations and subjective elements as constitutive parts of DMC evaluations, making them a subject of discussion instead of maintaining false promises of objectivity. We are convinced that more transparency in this regard helps clinicians and improves the adequacy of DMC evaluations. Firstly, clinicians get a fuller picture of the evaluation process. There is evidence that healthcare professionals are insufficiently aware of the normative component of DMC evaluations. A recent study has shown that one in five physicians is not aware that their personal values have an influence on DMC evaluations (Hermann et al. 2015). Secondly, normative considerations would become more amenable to critical reflection, which is a necessary prerequisite for proper handling of undue personal biases and a balanced argumentation and justification of the final judgment.

More explicitness could empower clinicians and help them arrive at a judgment with more confidence and a greater sense of certainty. Thirdly, making normative considerations more explicit increases transparency, intersubjective traceability and contestability. Arbitrariness or undue personal biases are more easily debunked.

In this paper, we present a new tool that aims at guiding clinicians through the evaluation process while making the underlying normative considerations more explicit and transparent. We will also report on findings of a pilot study exploring the benefits and difficulties of the tool by means of qualitative interviews with healthcare practitioners.

TOOL DESIGN

As the above-mentioned propositions suggest, the translation of descriptive data into a DMC judgment is a rather complex process. Evaluators need to reconcile descriptive data, moral intuitions and deliberation. They need to critically reflect personal influences, to appraise whether their judgment is still reasonable or exceeding their scope of discretion, and finally to give reason for and to document their judgment. We aimed to develop a tool that is able to address these challenges by including sections to guide the deliberation and judgment process in coming to a final decision on a patients' DMC. It can supplement existing interview guides that address the assessment of mental abilities.

The guide presents as a two-page form and is called *U-Doc*[2]. The *U-Doc* is primarily used during or after the encounter with the patient, but may also be helpful for preparation of the interview. The *U-Doc* consists of three sections (see Annex). In section 1, the specific situation/decision is described and the reasons for a thorough DMC evaluation are documented. In so doing, proper consideration is given to the decisional specificity of DMC and the a priori assumption of competence which requires initial reasonable doubts of a person's competence.

[2] „U" stands for the Swiss German term „Urteilsfähigkeit" (decision-making capacity).

In section 2, the appraisals of patients' mental abilities and impairments are documented. The list of criteria is dependent on and must be adapted to the specific legal context. The *U-Doc* has been developed in Switzerland. In line with Swiss legal doctrine, 12 criteria have been formulated and clustered within three overarching categories (*capacity for understanding; capacity for appreciation; formation and realisation of a will*).[3] Criteria are mostly comparable with those in other legal frameworks. Notably, emotional and motivational factors are explicitly included. For each of the criteria, a person's mental abilities may be appraised as *unaffected*, *impaired* or *unclear*. Alternatively, or in addition, an aggregated evaluation on the level of the overarching categories is possible with the following rating options: *unaffected*, *slightly impaired*, *moderately impaired*, *strongly impaired,* or *unclear*. Such appraisal may be further substantiated with a description of impairments.

The appraisal of mental abilities is followed by translation into a competence or incompetence judgment and its justification which is supported by section 3 (consisting of four elements). In a first step, the evaluating person is asked to work on a flowchart giving answers to three relevant normative questions: (a) are the *criteria* - those with impairments - *relevant* for the particular decision at hand; (b) are the *impairments* of mental abilities *significant*; and (c) are the impairments *compensated* by intact mental abilities. Question a takes into account the decisional specificity of DMC (Grisso and Appelbaum 1998b): depending on the complexity and consequences of the decision, only some of the 12 criteria may be relevant. Question b targets the threshold of impairments, and with question c it is taken into consideration that a person is more than her or his deficiencies and that for a comprehensive perspective it is important to include a person's psycho-social resources and abilities as well.

[3] The tool was developed alongside guidelines on the evaluation of decision-making capacity in medical practice issued by the Swiss Academy of Medical Sciences in 2019 and is consistent with the guidelines' set of core principles (cf. https://www.samw.ch/en/Publications/Medical-ethical-Guidelines.html).

By answering these three questions the evaluator arrives at a competence or incompetence judgment, which can be substantiated in an additional text field, together with notes regarding further relevant information such as support interventions, need for further evaluations, a second opinion or re-evaluation at a later point in time.

Since the Swiss law requires the existence of a legal cause for an incompetence judgment, an additional field to indicate the cause is provided in this section.

In a final step, the evaluating person is required to indicate whether or not he or she has critically reflected upon personal biases and conflicts of interest, and to assert that potential biases do not inappropriately influence their decision.

The intention of the *U-Doc* with its distinct sections is to foster awareness of the range of aspects that are relevant to DMC judgments such as to stimulate critical reflection on normative considerations, the evaluating person's subjectivity, and in particular their personal biases. Importantly, normative aspect shall not only become salient in section 3 but already in section 2. The need to rate criteria without having concrete operationalisations or scoring instructions shall initiate reflections on what it means to be *unaffected, slightly impaired*, *moderately impaired* or *strongly impaired* with the effect that one becomes aware of one's personal point of reference and the possibility that others could see it differently. In an ideal scenario, the *U-Doc* would stimulate an inclination to compare and discuss one's ratings with a colleague to challenge and finally to assure one's view.

PILOT STUDY

The development and refinement of the *U-Doc* was carried out in an iterative process over several months on the basis of workshops with collaborators of different backgrounds (ethicists, physicians, psychologists, tool designers), profound exchange in a commission of the Swiss

Academy of Medical Sciences[4] to formulate official guidelines on decision-making capacity (September 2015 until November 2018), and a *qualitative study* with healthcare practitioners (physicians, nurses and psychologists) consisting of a 2-hour training session on the concept and evaluation of DMC and the *U-Doc*, followed by a 4-month trial in clinical practice and a subsequent 1-hour face-to-face interview on the experiences made with the *U-Doc* (November 2016 until November 2017).

For the qualitative study, a purposive sample was used consisting of healthcare practitioners who are regularly confronted with doubtful DMC cases, and, as a group, cover a range of different specialties and fields of practice. Study participants have been recruited via health-institutions within German-speaking Switzerland. A total of 24 healthcare professionals including nurses, physicians, and one psychologist were willing to give feedback on the experiences with the *U-Doc* in an interview (of 84 professionals who took part in the training). The interviews were audio recorded and were transcribed verbatim. Analysis was done inductively, without pre-determined categories, using thematic analysis (Braun and Clarke 2006). We used the MAXQDA12 software to code the data. Several categories of codes have been identified. In this paper, only findings are reported concerning the relevant categories *perceived benefits* and *perceived problems* of the *U-Doc* in arriving at a judgment of (in)competence. The quotes have been translated from German to English and checked for language inconsistencies.

FINDINGS

The interviewees reported a range of different benefits of the form. First of all, the *U-Doc* provides *orientation*. It includes information on what DMC is, and which elements it comprises.

[4] The *U-Doc* has been included in the official guidelines on DMC published 2018 by the Swiss Academy of Medical Sciences (SAMS): https://www.samw.ch/de/Ethik/Autonomie-in-der-Medizin/Beurteilung-der-Urteilsfaehigkeit.html (last accessed on March 31, 2019).

Thus, the *U-Doc* has an educative function conveying basic knowledge. This is regarded as a basic prerequisite to start out on DMC evaluations with the necessary confidence (see e.g., table 1, quote 1).

Second, the *U-Doc* enables a *holistic perspective* on the patient meaning that it focuses not only on the deficits of the patient, but for example takes also into account biographical information, or more generally, the patient's psycho-social resources. As a result, the *U-Doc* is perceived as being impartial with regard to the conclusion, i.e., it is not merely a form to confirm a patient's incompetence but may also support and provide positive arguments for a competence judgment (see e.g., table 1, quote 2).

Third, the *U-Doc* helps the clinician to *think through* the decision, to *argue* and to *justify* one's conclusion, and this way it helps to strengthen clinician's confidence (see e.g., table, quote 3 and 4). Moreover, this includes also a *reflection of one's own intuitions and values*. The *U-Doc* sensitizes clinicians for their own subjectivity (see e.g., table 1, quote 5 and 6).

Forth, the *U-Doc* provides the clinician with a *vocabulary* which is perceived as highly useful to formulate reports or to communicate the decision to involved parties (e.g., patient, substitute decision makers, authorities) (see e.g., table 1, quote 7).

Finally, the *U-Doc* may serve as a basis for professional case discussions. It is regarded as a helpful guide to structure the collection of information from different persons and a following case discussion (see e.g., table 1, quote 8). By all these support mechanisms, the *U-Doc* can help clarifying a patient's DMC.

Table 1. Quotes regarding perceived benefits of the *U-Doc*.	
1	*«The benefit for me is, that since having it, I attend to this topic more concretely. Whenever the question of DMC came up in the past, although seldom, I was at a loss and then had to read up on what this actually is, how it is defined. Then, often also*

	tried to delegate this assessment to someone else, as I wasn't familiar with it. It really helps, I feel more confident with it, as I understand which factors it is composed of, what I have to consider, what I have to include in the assessment.» (interviewee 2)
2	*«Yes, and in particular it isn't merely deficit oriented. Very often in healthcare, we are very deficit oriented. We focus on: Where is the problem and how can we solve it. And in this case it is open for discussion. Can he or can't he do it. It is also possible, that he can do it. I liked that as well. That it is equally possible to be a "Yes", and not just: If he can't do this, if he can't do that and that, then surely he must be incompetent, but instead we effectively have both options available.»* (interviewee 9)
3	*«[...] one simply has a tool at hand, which helps one with it, a relatively difficult decision, which is of some significance to the patient, somehow, to reconsider, to reflect and then to be sure, to have reflected it and have done so according to objective criteria as much as possible. That is what was the key benefit of it [U-Doc]. And that conveys a sense of certainty, when one has the feeling – possibly in parts also a false sense of certainty, as it can fluctuate, but one has the momentary sense of not just having decided based on what I believe, but rather I have decided because I have looked at the criteria and noticed, that he seems to be competent to do this and that.»* (interviewee 9)
4	*«That I can somehow substantiate the judgment, for myself, and even if only for myself. Yes, I do stand to this, I thought about it. This is surely useful*.» (interviewee 1)
5	*«Thus far, it [experience] has stood the test of time, but I think, we could live more sincerely, and therefore the gut feeling – there is research on it, the gut feeling, and it is at times not so reliable – therefore I think, that one is to look at it again accurately and become conscious as to where the gut feeling has decided, and where have I informed myself carefully and generated sufficiently enough a basis for the decision,*

	that would be good. So that is why I liked [the U-Doc], because naturally – I am also one of these people, who very much decide based on gut feelings, but at least I'm well aware of that.» (interviewee 12)
6	*«That is what I find fascinating about it, it helps to scrutinize one's own perception a bit. As it can happen, that one gets prematurely fixated, and that one can then deliberate about it once more.»* (interviewee 23)
7	*«Hence, the description is sometimes difficult, to formulate this aptly in the judgment - the description, the notional descriptions that is. This helps me, so that I understand, how I can formulate it.»* (interviewee 2)
8	*«Now let us sit down and shed light into the situation by means of this instrument […] Yes, I would see this as the potential of the U-Doc. And then – I mean, when we discuss – everyone has his own conceptions and maybe also incomplete information. Someone might have deliberated it, but has no conception of emotions and motivations. So that we can collate the information within the group. And often, when everyone is fully informed, the disparities may then no longer be as great, but I do observe, that one tends to fixate on the information one already has.»* (interviewee 14)

The interviewees also named some difficulties with the *U-Doc*. Interestingly, they partially concern similar aspects which were positively evaluated by others as mentioned above.

First, it has been criticised that the proposed criteria are not completely separate from each other, but have a certain *overlap* making a clear assignment sometimes difficult. For example, a person who refrains from treatment due to a strong anxiety of injections could be categorized as someone who is impaired on the criteria *emotional involvement* because her emotions are too overwhelming or intense (to the effect that they impede rational thought), or alternatively may be seen as someone who has a problem with *weighing information/reasons for decision*

giving the anxiety more weight than the potential benefits of the treatment. Thus, one and the same observation can be interpreted in different ways and therefore assigned to different criteria. This has been regarded by some participants as confusing and complicating (see e.g., table 2, quote 1).

Some interviewees found the *room for interpretation* or the *subjective element* in general as rather unsettling. They wish to have more objective criteria with explicit rating instructions and scores which first ensure interrater reliability and second allow a clear answer regarding the patient's DMC. These participants felt not sufficiently supported by the *U-Doc* with the final decision (see e.g., table 2, quote 2 and quote 3). However, most of them were also aware that their wishes were hardly convertible into practice.

Finally, participants said that the *effort and time* required to fill in the form (depending on the case, up to 30 minutes) is a problem. Furthermore, it requires also time and effort to become acquainted with the *U-Doc*. Interviewees regarded a personal introduction to the *U-Doc* – as delivered in the training – almost a prerequisite.

Table 2. Quotes regarding perceived difficulties of the *U-Doc*.	
1	*«Hence, what I found partially difficult, was just that, practically speaking an impairment had to be assessed according to only one criteria. That I found difficult, to consider, to which criteria to match it. Because, just. At times there are simply two, three aspects affected, whenever something comes together. And then the one thing is affected, but the other as well and one then has to select.»* (interviewee 9)
2	*«It has given me a structure. It didn't give me certainty, because I realized, that if I do this "a bit like this or a bit like that", where should I, or! Hence, the decisions, where to put the check marks, they often were based on gut feelings. And in particular*

	in the discussion with the senior physician we noticed, that we assess certain aspects partially different.» (interviewee 1)
3	*«I've put the check marks here and then these questions follow "Are these criteria relevant?" – yes they are. "Are the impairments significant?" – yes, they are as well. But then the question follows "Are these impairments compensated by intact competencies?". Then one is back to square one. […] The check marks [in section 2] do not support me in answering this question [in section 3]. As it isn't a score-system, i.e. for example (7x "strongly impaired") + (3x"lightly impaired") = incompetent. Instead one is then left alone with the decision. […]medical practitioners always like scores.* (interviewee 22)

DISCUSSION AND CONCLUSION

Dealing with the question of how to reasonably support clinicians in arriving at a valid DMC judgment, we have developed and tested a new type of DMC evaluation tool that differs from existing ones by supporting the reflection of clinicians with regard to their personal values in order not to impose their views on their patients and thereby introducing unjustified medical paternalism through the back door.

By putting greater emphasis on the judgmental process rather than on the measurement of mental abilities the clinician as a decision maker is brought more into focus. The result is a form that is more like an *evaluation guide and documentation support* for the clinician than an instrument to assess the patient. As such, the tool is less oriented towards performance criteria such as objectivity, validity and reliability, but more concerned with a structured, thorough, deliberate and critically reflected decision-making process.

Acknowledging the unavoidable normative considerations involved in DMC evaluations, a primary purpose of the proposed tool is to foster awareness of and critical reflection on value

judgments and subjective biases. It is not about eliminating interrater variations in the first instance but instead to make them more visible and to sensitise for them. As the findings of the pilot study suggest, the *U-Doc* is effective in this regard.

Furthermore, revealing the subjectivity inherent in DMC evaluations stresses the need for intersubjective verification and contestability, or exchange with other professionals and third parties (Grisso and Appelbaum 1998b; Freyenhagen and O'Shea 2013). The *U-Doc* has been regarded as a useful basis for this kind of discussion. A probable result is a more openly debated professional discourse on the nuances of DMC evaluations, and greater confidence for the individual evaluator who knows that their subjective perspective is supported, or has been aligned with the views of others.

As the present study shows, additional confidence is generated through setting out one's observations, appraisals and arguments in writing. One is better able to retrace one's thoughts at later point in time and can explain and justify the judgment to oneself and others. A completed form thus provides a comprehensive documentation of the evaluation.

Challenges concerning the implementation can be expected regarding the acceptance of the tool. First, the *U-Doc* may appear rather extensive and time-consuming. In addition, the explicitness of value judgments and of subjective elements, the scope of discretion, including certain ambiguity, and the related individual responsibility that is accentuated may be unfamiliar and therefore provoke resistances. It is known that a high proportion of clinicians conduct DMC evaluations implicitly without supportive tools (Hermann et al. 2014). Despite their wish for more guidance in this area, it would not be surprising if any new tool was initially perceived as generating more workload. Moreover, the tool may not meet clinicians' expectations as it does not provide a simple algorithm or test that they may have hoped for. Nevertheless, we believe that once clinicians engage with the tool and gain experience with it, rapid learning effects will result in substantial reduction of time needed. Clinicians will probably internalise relevant

criteria, be more aware of their intuitions and personal inclinations, know about potential pitfalls and feel more competent to argue adequately and thoroughly.

The proposed evaluation guide would benefit from further empirical testing. Once this is accomplished and the tool further refined, there will also be new opportunities for research on DMC that is able to look more closely at the currently obscure judgment process, the involved value considerations and the justification of final DMC judgments.

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